TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME LLC

Respondent Name
TASB Risk Mgmt Fund

MFDR Tracking Number
M4-15-3572-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 29, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We should be paid for services rendered because we have submitted appropriate proof of timely filing."

Amount in Dispute: $535.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was processed according to the W.C. fee schedule, rule §134.203 (d) (1)."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2015	E0217	$535.11	$58.79

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 set out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 193 – Original payment decision is being maintained.
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. Was Medicare coding and billing requirements met?
2. What it the applicable rule that determines reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The service in dispute is for the rental of Durable Medical Equipment.

   Review of the submitted documentation finds;

   a. The submitted medical claim indicates units of "7".

   28 Texas Administrative Code §134.203 (b) states,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits;

   Review of the DMEPOS fee schedule finds a monthly rental is allowed. Insufficient evidence was found to support that a daily amount should be allowed. Therefore, the service in dispute will be reviewed per the applicable fee guidelines and rules.
2. Per 28 Texas Administrative Code §134.203 (d) "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;" Review of the submitted documentation finds
   a. Applicable fee schedule for date of service finds, "TX, RR, $61.35"
   b. Per Division guidelines the maximum allowable reimbursement = $61.35 x 125% or $76.68.
3. The total maximum allowable reimbursement is $76.68. The Carrier previously paid $17.89. The remaining balance of $58.79 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $58.79.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $58.79 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		September , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.